February 13, 2001

Dear Dr. Trujillo;

In your August 28, 2000 letter to tribal leaders, you stated that the Level of Need Funded (LNF) Workgroup was "to continue refining a methodology for the Indian Health Care Improvement Fund that considers the feedback from tribes and Indian health leaders." Members of the LNF Workgroup have participated in three regional consultation forums to hear directly from tribal leaders and also have reviewed more than a hundred letters and position papers from tribes. Following the consultation forums, the Workgroup met February 6-8 in Denver, Colorado to discuss the tribal views and to propose revisions to the LNF methodology accordingly. This letter contains our recommendations for improving the LNF methodology and the related resource allocation formula.

Before outlining our proposals, it is appropriate to briefly review the history of the LNF issue as a means of placing in context our recommendations concerning the FY 2001 Indian Health Care Improvement Fund (IHCIF).

BACKGROUND

The provision of a broad scope of health and public health services to the American Indian and Alaska Native (AI/AN) Tribes is a continuing responsibility of the U.S. government. Historically, these services have been provided through annual discretionary funding provided to the Indian Health Service (IHS). Over the past thirty years there has developed a chronic pattern of under funding. In recent years, the Congress has failed to provide sufficient funds to address even natural population growth and medical inflation. The resulting erosion of buying power has contributed to the disparity in health status among AI/AN communities.

In 1992 the Congress attempted to address this situation through the enactment of Section 1621 of the Indian Health Care Improvement Act, which authorized the IHCIF for "eliminating the deficiencies in health status and resources of all Indian tribes". Sadly no funds were appropriated to the IHCIF until eight years later. In December 1998 you created the LNF Workgroup and assigned to us the responsibility to develop a methodology to identify the health status and resource deficiency for each Indian tribe as required in the Act.

In developing the methodology, the Workgroup has tried to uphold core principles of comparability and credibility based on objective data. Fundamentally, the LNF methodology makes an "apples to apples" comparison between the cost of service provided to the IHS active users and the cost of services provided by the Federal Employees Health Benefit Package, a mainstream health plan available to federal employees through out the nation. This comparison addresses personnel health care services, the core activity of the agency, but not the full scope of IHS services which

include critical public health, environmental, and community sanitation programs. The approach we selected is based on an actuarial analysis of the IHS active user population that seeks to identify health care funding for AI/AN that is comparable to other Americans of similar age and health characteristics.

In FY 2000, Congress appropriated $10,000,000 in the IHCIF. This is contrasted to a national IHS shortfall $1.3 billion that we identified in our Phase I LNF Report. The Congress also directed the IHS to use the LNF methodology to distribute the IHCIF fund. Although the Phase I LNF Report was widely hailed for identifying the high level of under funding using scientific methods, many tribal leaders also felt that the allocation formula, which is based on funding deficiencies identified by the LNF methodology, was not sufficiently tested to justify a recurring distribution of the $10,000,000 and suggested further refinements.

In response to this situation, the Congress appropriated an additional $30,000,000 in the IHCIF for FY 2001 and directed the IHS to continue to work with the Tribes to refine the formula. Subsequently, three regional consultation meetings were held for the purpose of collecting an extensive list of adjustments and improvements to the LNF methodology. The Workgroup discussed this list extensively on February 6-8, 2001 at our meeting in Denver, Colorado. Our discussions have resulted in a series of revisions to the methodology for your review and subsequent review by tribal leadership at a National Consultation Meeting scheduled for March 6-7, 2001 in Albuquerque, New Mexico. It should be noted that several of the key decisions reflect a continuing division of opinion and that some concerns will require further review and analysis as part of the annual iterative process of LNF update and review.

REVISIONS TO THE LNF RESOURCE ALLOCATION FORMULA

Taken together, all of the recommended revisions produce moderate changes in results compared to FY 1999. ***Please note that estimates cited here and in attachments are approximate and may change as data are finalized in the next few weeks.***

For FY 2000, the revised LNF methodology identifies $3.5 billion needed to assure personal health care services to IHS active users that are comparable to those available to federal employees, an increase of $400 million over the estimate for FY 1999. The IHS funds available for personal medical services identified in FY 2000 are $1.8 billion, which is essentially unchanged from FY 1999. The resulting LNF percentage for IHS in FY 2000 is 51%, down from 57% in FY 1999. These results primarily are due to 2% more Indian users and 8% higher medical costs and the exclusion of additional IHS funds for wrap-around programs. Even though the overall IHS budget increased in FY 2000, extensive tribal comments identified substantial amounts of funds that were counted for personal medical services in FY 1999 that should have counted for "wrap-around" programs instead. For instance, the revisions for FY 2000 exclude 63% of contract support costs, more than $60 million for patient travel costs, and $36 million for the Community Health Aids Program in Alaska.

Based on the methodology as we have revised it, we estimate that an additional $1.7 billion is needed to fund IHS and tribal operating units at a level comparable to the Federal Employees Health Benefits Plan. It would require an appropriation of $51 million to bring the lowest funded operating units up to 40% and an additional $352 million to bring all operating units up to the 60% level.

The LNF methodology that we recommend contains the following revisions:

1. The LNF benchmark cost per person was $2,980 in 1999. The benchmark for FY 2000 is increased to $3,221 per person consistent with an 8.1 percent increase in the cost of mainstream employer sponsored insurance plans. This adds $343 million to funding needs.

2. The FY 1999 methodology was based on 180 operating units. The number of separate operating units increased to 236 in FY 2000. This change is due to the breakout of operating units in Alaska, Portland, and Phoenix Areas, which had been grouped inappropriately as a collection of tribes in FY 1999.

3. A baseline count of 1.4 million active users was determined from FY 1998 IHS user counts. The workgroup had strongly preferred 1999 user counts. But these are unavailable due to continuing tabulation and verification problems.

4. The workgroup included 25,000 additional active users who, according to IHS data reside within IHS Area boundaries and regularly obtain services at an IHS or tribal health care facility, but were not counted as active users in FY 1999 because they live outside Contract Health Service Delivery (CHSDA) boundaries. This adds $80 million to funding need.

5. Additional data items were obtained directly from IHS and tribal operating units in FY 2000. The purpose was to identify more accurate price indices for purchased medical services based on actual patient referral patterns. New data submitted by the operating units include:

    a. The percentage of medical services that are purchased
    b. The location for primary care referrals
    c. The location for specialty care referrals
    d. The price indices for primary and specialty referral locations are averaged in the LNF model

6. The workgroup set a floor medical price index for purchased medical services. We believe extremely low price index values, which are typical in some rural areas, are unrealistic for the Indian health programs. After applying the floor and related data calibrations among all 236 operating units, the lowest purchase price index actually assigned any operating unit is 91% and the highest value assigned any operating unit in the lower 48 states is 123% of the national average.

7. The workgroup declined to increase the average price adjustment for Alaska above 138% that was approved in FY 1999. For FY 2000, 125% is applied to operating units in the Anchorage region and 148% is applied to other Alaska locations to maintain the 138% statewide average. The Alaska LNF workgroup representative has submitted a dissenting opinion on this item. In recognition of the isolation of 229 villages throughout remote areas of Alaska, $36 million of costs for the Alaska Community Health Aid program is excluded as wrap-around. Similarly, the workgroup excluded additional patient transport costs in Alaska up to a maximum of $32 million based on validated costs.

8. The workgroup reaffirmed a cost adjustment in the IHCIF formula to be applied to internal costs based on size of the operating unit. The adjustment is premised on better cost efficiency for larger operating units and lower cost efficiency for smaller operating units. Internal costs are the costs of providing personal health care services to active users with the internal workforce of the operating unit as contrasted to the costs of purchasing those services externally. The cost adjustment ranges from a low of 87.5% for the largest operating unit to a high of 130% for all operating units with less than 900 users.

9. The workgroup is replacing the health status index used in methodology in FY 1999. In the formula, the health status index adjusts needed funding for the varying disease burden as measured among IHS areas. The new health status index for FY 2000 is composed of the following factors:
    a. 15% for birth disparities (low and high birth weight infants)
    b. 75% for disease disparities based on excessive rates of injuries, heart disease, diabetes, cancer, and alcoholism among the Indian population
    c. 10% for number of users older than 54 years of age
    d. If the disease rate was an extreme low outlier, due to incomplete identification of Indians in various data sources, the workgroup substituted the data rate observed of the next closest IHS area rate.

    The new health status index adds costs that range from $1,017 per user for operating units in the Area with lowest health status index to $525 per user in the Area with the highest health status index. The average adjustment is $644 per person for low health status among Indians compared to other Americans (e.g., without a health status adjustment, the benchmark cost would be $2,577 per active user rather than $3,221 per active user).

10. The workgroup excludes 63.4% of Contract Support Costs (CSC) based on a technical workgroup analysis. The exclusion is required to maintain internal equity between direct service programs and self-determination programs. This excludes $134 million for self-determination programs due in part to certain unique costs for tribal contracts/compacts that are not required of Federal programs and in part to higher costs experienced by tribes when they operate health delivery programs independent of the Federal system. Similarly, 63.4% of the 20% portion of headquarters and area office tribal shares related to CSC type

costs are also excluded for both direct service and self-determination programs.

11. Depreciation for federally funded hospitals and clinics that are under 30 years of age is counted as an available resource. If the balance of facility assets is less than the cost to correct facility life and safety code violations, no depreciation is counted. Depreciation that was funded with Maintenance and Improvement funds, which already are counted in the formula, will not be double counted.

12. A $745 discount for coverage from other sources (Medicaid, Medicare, and Private Insurance) was applied in FY 1999. This amount is inflated by 6% to $790 for FY 2000 based on national average increase in Medicaid expenditures.

13. Efforts to improve the accuracy of financial data for individual operating units were instituted for FY 2000. Foremost among these is the itemization of tribal shares for IHS headquarters and Area offices to avoid duplicate counting. This is one reason for more accurate accounting of available resources counted towards personal health care services versus wrap-around programs.

14. The workgroup considered several allocation formula options for FY 2000 including a tiered allocation among all operating units with less than 100% of need. It approved a formula that targets allocations to operating units that are funded at less than 60% of need. This policy is consistent with the approach in FY 1999 and with Congressional direction to focus Indian Health Care Improvement funds to tribes that are "most in need".

15. The Congress urged consideration for a minimum allocation to operating units qualifying for IHCIF funds. The workgroup set a minimum of $10,000 per operating unit for any IHCIF allocation.

16. The workgroup reaffirmed that $40,000,000 in the Indian Health Care Improvement Fund ($10,000,000 from FY 2000 IHS appropriation plus $30,000,000 from the FY 2001 IHS appropriation) be allocated to local operating units by formula in FY 2001 and that such allocations be made recurring to the operating unit in years thereafter.

17. The workgroup reaffirmed the need for continuing review and improvement of the LNF methodology on an annual basis. This may include additional actuarial studies to revise or replace the existing price benchmark.

CONTINUING ISSUES OF CONCERN

There is a list of serious and in some cases long standing issues of concern that the IHS is urged to address as quickly as possible. The most troubling of these concerns is the continuing failure of the IHS to produce unduplicated active user counts in a timely manner. Although the Workgroup recognizes that the IHS has made considerable efforts over the past two years to improve data collection systems, these efforts have yet to

accomplish their goal. Sufficient resources must be marshaled at all levels to overcome these problems.

A consistent theme heard in all three regional consultation meetings is the need for a rigorous data driven formula to identify funding needs for public health, outreach and environmental health services not addressed in the LNF methodology. We urge you to charge a workgroup to develop a methodology for wrap-around programs this year.

A significant portion of the tribal leaders who participated in the regional consultation meetings expressed opinions that the LNF methodology should not include third party coverage available to Indian people including Medicaid, Medicare, private health insurance and the new Children's Health Insurance Program. This opinion is driven in part by a feeling that increased reliance on these funding sources represents a rollback of the federal trust responsibility to Indian Tribes. Another reason expressed is that access to health care for Indian people should not be subject to means testing. Inclusion of these resources in the LNF methodology, however, is responsive Congressional directives established in statute in Section 1621 of the Indian Health Care Improvement Act. The Workgroup urges that you communicate as forcefully as possible to the new Administration the critical role that the IHS plays in providing access to heath services and coverage to the Indian community.

The Health Care Financing Administration is the second largest funding source for health care services to the Indian community through its Medicaid, Medicare and S-CHIP programs. This activity has created a large body of encounter level data on health care services to AI/AN. Unfortunately there is a high level of misidentification of Indian Tribal status in this database. The IHS active user data set clearly identifies the Indian population that depends on the IHS as its primary health care provider. Matching these two data sets would provide the information to more fairly identify third party coverage by operating unit. And, perhaps more importantly, it would provide the encounter level information necessary to update the cost benchmark for personal medical services. The Workgroup urges you to establish the necessary collaboration with HCFA to carry out this research.

In the past several years, a significant number of tribes and health programs have responded to the lack of federal facility construction funding by entering into long-term debt to finance replacement of old and inadequate health care facilities. An extensive study done by the National Indian Health Board has documented the importance of this trend to the viability of the IHS funded health care delivery system. Servicing construction debt is generally accomplished through a long-term commitment of third party income, which would otherwise be available for the provision of health care services to tribal members. The task group recommends that the IHS develop a national database that would identify any health facility financing costs incurred by tribes so that any debt payments may be discounted from the LNF methodology.

In FY 2000, the LNF Workgroup has included counts of AI/AN who live outside of designated Contract Health Service Delivery Areas (CHSDA) who regularly obtain direct

care services in IHS and tribal health facilities though they are ineligible for referral under CHS. This approach rightly identifies the financial burden of providing care to these persons. However, this expanded definition may exclude additional Indian users who reside in states that are not included in the twelve designated IHS Areas or who reside in counties designated as Urban Indian service areas. There is a similar concern related to "crossover" users who reside in one Area or operating unit and crossover to another Area or operating unit to receive a portion of their services. We recommend that the IHS develop a more precise system of patient registration and frequency of facility usage that more accurately accounts for the real financial burdens experienced by operating units where substantial cross-over utilization occurs.

The LNF methodology is an actuarial based method of resource planning and distribution. It relies on techniques long used by both private industry and other governmental programs to calculate resource requirements. The LNF Workgroup recommends that the IHS further integrate the LNF approach into its budget development and justification activities. The identification of a $1.7 billion shortfall in IHS funding for personal health care services for fiscal year FY 2001 is solid evidence of a historic under funding of health care for Indian people.

For the past two years the LNF Workgroup has struggled with the problem of identifying an appropriate cost index for health care services provided in the Alaska Area. The vast size of that Area, the extreme remoteness and dispersion of much of its service population and the unique delivery system that has evolved there complicates the assessment of need in that Area. Most of Alaska is best understood as being outside of the experience of normal health care markets and, as a consequence, cost/price data comparable to that in the lower 48 states are rarely available in Alaska. At the recent Denver LNF Workgroup meeting, three proposals to adjust the LNF model for unique Alaska costs were considered. Although the Workgroup approved two of these proposals, it rejected the third by a narrow margin of opinion. A formal note of dissent from this action by the Alaska delegate is attached for your review. It is perhaps inevitable that the cost of care in Alaska will continue to be a divisive issue, which will require additional research, discussion, and possible adjustments.

We have attached initial results from the revised LNF model for your review and consideration. ***Again, please be aware that the attached draft results are for consultation purposes and may change before the March consultation meeting due to certain data refinements now underway.*** We look forward to meeting with you and the Tribal Leaders at the national Tribal Consultation meeting scheduled for March 5-9, 2001 in Albuquerque, New Mexico.

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Enclosures